STATEMENT OF REASONS
FOR RULE CHANGES UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

As required by Section 11346.2 of the Government Code, the Commissioner of Corporations ("Commissioner") sets forth below the reasons for the proposed adoption of subsection (h) to Section 1300.67 and Section 1300.68.2 to the California Code of Regulations (10 C.C.R. Secs 1300.67 and 1300.68.2. ).

Assembly Bill 892 (Chapter 528, Statutes 1999-Alquist) added Section 1368.2 to the Health and Safety Code. Section 1368.2 requires all health care service plan ("plan") contracts, except for specialized plan contracts, on or after January 1, 2002, to include hospice care, as a basic health care service. At a minimum, hospice care shall be equivalent to that provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act in Title 42 of the Code of Federal Regulations, Chapter IV, Part 418, except Subparts A, B, G, and H (the "federal regulations") and any amendments or successor provisions. AB 892 further requires the Commissioner, by January 1, 2001, to adopt regulations to implement Section 1368.2. These regulations shall be consistent with:

(1) all material elements of the federal regulations that are not by their terms applicable only to eligible Medicare beneficiaries;
(2) any other applicable federal or state laws; and
(3) the definitions of Health and Safety Code Section 1746 of the California Hospice Licensure Act of 1990 (the "state Hospice Act").

Section 1300.67 describes minimum basic health care services that a plan must provide to its enrollees. The Commissioner proposes adopting subsection (h) to Section 1300.67 to include hospice care as a basic health care service. New subsection (h) is necessary to clarify hospice care as a basic health care service and provide consistency between the statute and the regulation.

The Commissioner proposes adopting Section 1300.68.2 to identify and consolidate the provisions of federal and state law that are applicable to the implementation of Section 1368.2. These provisions are needed to clarify the plan's obligations for coverage of hospice services.

Subsection (a) of Section 1300.68.2 defines various terms used in connection with this section. Except where specified below, these definitions are consistent with the definitions used in Section 1746 of the Health and Safety Code as well as with the federal regulations as required by Section 1368.2 of the Health and Safety Code and are incorporated into this section for purposes of clarity.

Subparagraph (1) of subdivision (a) defines the term "bereavement services" to mean those services available to the surviving family members for a period of at least one year after the death of the enrollee and includes an assessment of the needs of the bereaved family and the development of a care plan to meet those needs. This provision is necessary to clarify the scope of coverage required to be provided by plans.

Subparagraph (2) of subdivision (a) defines the term "hospice" to mean a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an individual during the last phases of life due to the existence of a terminal disease, to provide supportive care to the primary care giver and the family of the enrollee and which meets all of the following criteria: (1) considers the enrollee and the enrollee's family, in addition to the enrollee, as the unit of care; (2) utilizes an interdisciplinary team to assess the physical, medical, psychological, social and spiritual needs of the enrollee and the enrollee's family; (3) requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care, which emphasizes supportive services, including, but not limited to, home care, pain control, and limited inpatient services which are intended to ensure both continuity of care and appropriateness of services for those enrollees who cannot be managed at home because of acute complications or the temporary absence of a capable primary care giver; (4) provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease; (5) provides for bereavement services following death to assist the family to cope with the social and emotional needs associated with the death of the enrollee; (6) actively utilizes volunteers in the delivery of hospice services; and (7) to the extent appropriate based on the medical needs of the enrollee, provides services in the enrollee's home or primary place of residence.

This provision is necessary to provide notice to plans regarding the scope of coverage required to be covered under Section 1368.2 and is consistent with Section 1746 of the Health and Safety Code and the federal regulations.

Subparagraph (3) defines the term "home health aid services" to mean personal care services provided under a plan of treatment prescribed by the enrollee's physician and surgeon provided for the personal care of the terminally ill enrollee and the performance of related tasks in the enrollee's home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment. This provision also requires that home health aide services be provided by a person who is certified as a home health aide by the state Department of Health Services. This provision is necessary for clarity and to be consistent with the law.

Subparagraph (4) defines the term "homemaker services" to mean services that assist in the maintenance of a safe and healthy environment and services to enable the enrollee to carry out the treatment plan. The term "homemaker services" is not found in California law regarding hospice care services; however, it does exist in the federal Medicare hospice care regulations and is necessary for clarity and to fulfill the legislative mandate of AB 892 to adopt regulations that provide coverage for hospice care benefits that are at a minimum consistent with the federal Medicare standard.

Subparagraph (5) defines "interdisciplinary team" to mean the hospice care team that includes, but is not limited to, the enrollee and the enrollee's family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver. This provision is necessary to clarify the scope of required coverage.

Subparagraph (6) defines "medical direction" to mean those services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the

interdisciplinary team, a consultant to the enrollee's attending physician and surgeon, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. This subparagraph also provides that for purposes of this section, the person providing these services shall be referred to as the "medical director."

Subparagraph (7) defines "plan of care" to mean a written plan developed by the attending physician and surgeon, the medical director or physician and surgeon designee, and the interdisciplinary team that addresses the needs of an enrollee and family admitted to the hospice program. Subparagraph (7) also provides that the hospice shall retain overall responsibility for the development and maintenance of the plan of care and quality of services delivered and also provides that nothing in this section shall be construed to limit a plan's obligations with respect to its quality assurance program as required under Section 1300.70. This provision is necessary to clarify the scope of covered services required to be provided by the plan as well as to clarify the plan's obligations with respect to hospice care services.

Subparagraph (8) defines "skilled nursing services" to mean nursing services provided by or under the supervision of a registered nurse under a plan of care developed by the interdisciplinary team and the enrollee's physician and surgeon to an enrollee and his or her family that pertain to the palliative, support services required by an enrollee with a terminal illness. Subparagraph (8) further provides that skilled nursing services include, but are not limited to, enrollee assessment, evaluation and case management of the medical nursing needs of the enrollee, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the enrollee and his or her family, and the instruction of caregivers in providing personal care to the enrollee. Additionally, this subparagraph provides that skilled nursing services shall provide for the continuity of services for the enrollee and his or her family and shall be available on a 24-hour on-call basis. As nursing care needs are unique with respect to hospice care services as opposed to other types of health care services, this provision is necessary to notify the plans of the required scope of coverage.

Subparagraph (9) defines "social service/counseling services" to mean those counseling and spiritual services that assist the enrollee and his or her family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs. This provision is necessary to clarify the scope of coverage and to be consistent with existing law.

Subparagraph (10) defines "terminal disease" or "terminal illness" to mean a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course. This provision is necessary to notify plans as well as enrollees, subscribers and providers, as to when an enrollee or subscriber is eligible for hospice services. This provision is consistent with Section 1746 of the Health and Safety Code. However, it should be noted that under the federal regulations "terminally ill" is defined to mean that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course. Under AB 892, if there is a conflict between a federal regulation and any state regulation, other than those adopted pursuant to this section, the Commissioner is required to adopt the regulation that is most favorable to plan subscribers, members or enrollees to receive hospice care. In this case, the definition for "terminally ill" found under state law is more favorable to the enrollee, subscriber and member of the plan.

Subparagraph (11) defines "volunteer services" to mean those services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the hospice to provide direction to hospice volunteers. Hospice volunteers may be used to provide support and companionship to the enrollee and his or her family during the remaining days of the enrollee's life and to the surviving family following the enrollee's death. This provision is necessary to be consistent with state law and federal regulations.

Subsection (b) sets forth the coverage requirements for hospice services provided pursuant to Section 1368.2 of the Act.

Subparagraph (1) sets forth licensure and/or certification requirements that are consistent with the state Hospice Act. This provision requires that plans contract with hospices that are either licensed by the state Department of Health Services or certified in accordance with federal Medicare conditions of participation. This provision is necessary in order to be consistent with existing state law.

Subparagraph (b)(2) sets forth the hospice services that plans must provide at a minimum. These services are interdisciplinary team care, skilled nursing services, home health aide and homemaker services, social services/counseling services, medical direction, volunteer services, inpatient care arrangements, pharmaceutical, medical equipment and supplies, and certain rehabilitative therapies including physical therapy, occupational therapy and speech-language pathology services. These listed services reflect the applicable requirements in the state Hospice Act and the federal regulations. Requirements were determined to be applicable to these proposed regulations if they were relevant to issues surrounding their party coverage and could be required of plans. Since hospices are not regulated under the Knox-Keene Act, requirements were considered inapplicable if the only entities responsible for compliance are the hospices themselves.

Subsections (c) and (d) set forth requirements from the federal regulations that are compatible with, but not as specifically articulated in the state Hospice Act. These requirements specify services that must be available on a 24-hour basis, mandate that hospice care may be provided in the home or a facility and define special coverage requirements for periods of crisis and respite care. These provisions are necessary to provide notice to plans as to the scope of benefits that must be provided pursuant to Section 1368.2 of the Act.

Subsection (e) requires that every plan shall include notice of the coverage specified in subsections (b), (c), and (d) of the plan's evidence of coverage and disclosure form. This provision is necessary to ensure that enrollees and subscribers have adequate notice of what services are a covered plan benefit with respect to hospice care services.

Subsection (f) requires that all contracts between plans and hospices be in accordance with all federal and state licensure requirements. This provision is necessary to ensure that when plans contract with hospices, all contract provisions are consistent with the hospice's licensure requirements at both the state and federal level.

ALTERNATIVES CONSIDERED

No alternative considered by the Department would be more effective in carrying out the purpose for which the regulation is proposed, would be as effective and less burdensome to affected private persons, or would lessen any adverse impact on small businesses.

FISCAL IMPACT

Cost to Local Agencies and School Districts required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None.

No other nondiscretionary cost or savings are imposed on local agencies.

DETERMINATIONS

The Commissioner has determined that the proposed regulatory action does not impose a mandate on local agencies or school districts, which require reimbursement pursuant to Part 7 (commencing with Section 17500) of Division 4 of the Government Code.